Rural, WY 55555

Phone: 555-5555 Fax: 222-222-2222 Email: xyz@example.com

Website: http://mysite@example.com



SAMPLE FORMAT FOR INVOICE

DATE: March 3, 2010

TO: Michelle Hoffman, Program Manager

Office of Rural Health

6101 Yellowstone Road, Suite 259B

Cheyenne, WY 82002

FROM: Sam Jones, Director

Top Health Care

REFERENCE: REACH Program

Date of your event

Request for reimbursement as follows: (Total amount allowable for grant = \$2,000.00)

EXPENSES	COST
Transportation	
Driver Stipends (\$100 x 2)	\$200.00
Fuel	\$50.00
Food for Students and Helpers	
AM snacks (\$2.50 x 32)	\$80.00
Lunch (\$5.95 x 32)	\$190.40
PM Snacks (\$2 x 32)	\$64.00
Site Coordinator	
Plan, coordinate, travel, supervision	\$500.00
Supplies/Program Expenses	
Gloves	\$9.89
Glucose Testing	\$51.13
Blood Pressure Kits and Thermometers	\$29.98
Disability Equipment	\$128.00
Communications	
Student Folders (\$0.17 x 28)	\$4.76
Postage (\$0.43 x 150)	\$64.50
Copies	\$32.20
Newspaper & Radio	\$50.00
TOTAL AMOUNT OF THIS REQUEST	\$1,454.86

Please contact Sam Jones at (907) 335-2134, if you have any questions regarding this invoice.

Thank you,

Jane Doe

Accounting Director

NOTES: Please submit your invoice on your organization's letterhead. Please attach any backup forms to substantiate the charges, such as receipts or other documentation. Please clearly delineate the amount of your request.